Final Report

Continued Strengthening of Family Planning Supervision

Technical Assistance to INHSAC

HAITI

In Haiti, Community Based Distributors (CBDs) of modern methods of family planning played a crucial role in increasing contraceptive prevalence under the Private Sector Family Planning Project (PSFPP) which was conducted from 1986-1996. The second interim evaluation of that Project identified supervision as a key weakness to be addressed. In order to enhance the performance of field workers, USAID/Haiti requested that the Population Council devise and test mechanisms to improve supervision. Under a sub-contract from the Population Council, the Institut Haitien de Sante Communautaire (INHSAC) translated into Haitian Creole and adapted a decision tree manual that had been developed and successfully utilized in South America by the Population Council.

BACKGROUND

USAID/Haiti engaged the Population Council to conduct operations research (OR) in support of the PSFP Project through incremental funding to INOPAL II. The PSFP Project was managed in Haiti by IPPF/WHR and provided family planning services through subcontracts to non-governmental organizations working in both rural and urban areas.

Promoters of family planning formed the backbone of the Project. Typically, Promoters recruited new clients through home visits and distributed three methods to acceptors: condoms, oral contraceptives and vaginal tablets; a small number of Promoters were also Health Agents and provided Depo-Provera as well. By March 1994, CBDs accounted for 54% of all reported distribution. Through their referrals, Promoters were also responsible for attracting additional users of clinic-provided methods.

INHSAC

The Institut Haitien de Sante Communautaire was founded in 1986 to provide training in public health and became the principal training institution for staff working in family planning, child survival or STDs/AIDS. On-site training programs were conducted for three levels of staff: 1. physicians and nurses, 2. auxiliary nurses, and 3. voluntary collaborators and promoters. Gradually, more of the training of level three staff was conducted in the field.

In addition to training, the original mandate of INHSAC envisioned research related to training, but the institution had been unable to focus attention on this objective. USAID/Haiti was particularly interested that the Population Council work with INHSAC in order to strengthen their research skills and enable them to gain practical experience in conducting operations research.

Phase 1

Lack of promoter supervision was a fundamental weakness in many Haitian family planning programs. In general, agencies did not have supervisory systems with clearly articulated goals, norms, activities or supervisory instruments. In response to these problems, INHSAC with INOPAL assistance conducted an OR project with six agencies from March 15, 1994 through February 15, 1995.

A baseline assessment of 10 institutions funded through three umbrella organizations allowed INHSAC to select 6 service delivery organizations to participate in the research. The assessment also identified several specific problems with the supervisory system.

Haiti was unique among Latin American family planning programs in its continued use of annual user targets. Two supervisory systems (one featuring vertical, top down target setting, the other participatory target setting) were compared in four agencies, two pairs from two different umbrella organizations. The same supervisory instruments and training were used in each of the intervention groups. Over the course of the project, INHSAC developed needed supervisory forms, records, procedures, manuals and training techniques.

INHSAC assessed program performance through several measures, including the number of acceptors of family planning during three quarters: 1. prior to the intervention, 2. during the intervention, and 3. post intervention. The three-month project intervention period coincided with the international invasion of Haiti, nevertheless, service delivery continued. If anything could be determined, top-down supervision was more effective in encouraging Promoters in Haiti to attract new clients. We realized, however, that the emphasis on an increase in new acceptors may have resulted in over-reporting since the supervisory systems in use did not permit verification of the accuracy of reports.

The report forms and supervision guide developed were made available to the managers of all agencies working under the Private Sector Family Planning Project, but we still lacked concrete tools with which supervisors could assist and evaluate the work of Promoters. In addition, a survey of supervisors we conducted during Phase 1, identified that they did not succeed in making a field visit to even a half of 31 Promoters under their responsibility.

Phase 2

Our experience during Phase 1 allowed us to identify a number of weaknesses in the supervision of promoters. In particular, there were no mechanisms to verify the accuracy of promoter reports or to assess the technical content of promoter presentations. Also, managers of the program were concerned about client retention. We were interested in the positive experience of family planning programs in South America who used a work aid called the 'ABC' to improve the performance of promoters.

Our original design called for the introduction of the 'ABC' decision tree manual in Haitian Creole at intervention institutions. We wished to measure the impact of use of the ABC on promoter knowledge, new client retention, the content of promoter recruitment visits and on client knowledge. We planned to compare before and after measurements of these indicators from intervention sites to the same indicators at control institutions. Unfortunately, the development and testing of all the required instruments required more time than anticipated. The human resources available enabled us to measure before and after measurements at both intervention and control sites only of promoter knowledge. For the other variables, valid pre-intervention measurements were made only at the intervention sites as described under 'Methodology.'

METHODOLOGY

The Intervention - ABC Decision Tree Manual

The 'ABC' decision tree manual for the introduction of family planning was translated from Spanish into French. The French version was reviewed by a team of managers and supervisors from the Private Sector Family Planning Project who suggested modifications for use by Haitian promoters. The Research and Evaluation Unit of INHSAC developed a modified 'ABC' in Haitian Creole. The Creole 'ABC' introduced all modern methods, but concentrated on the methods offered by Promoters, namely, condoms, vaginal tablets and both combined as well as progesterone-only oral contraceptives. Promoters continued to refer clients interested in other methods to clinic staff who provided more complete information on the use and possible side effects of those methods.

During November and December 1995, INHSAC provided 18-hours of training in the use of the Creole 'ABC' to 28 Promoters, 90 Voluntary Collaborators and the supervisors from 4 intervention institutions. Although the original design called for 30-hours of training for promoters only, funding changes resulted in the decision by managers at the intervention sites to add family planning distribution to the tasks of the voluntary collaborators. They requested that INHSAC provide training to these field workers as well as to promoters. Subsequent field visits convinced INHSAC of the need to provide additional training in the use of the 'ABC.' INHSAC randomly selected 14 Promoters from among the 28 who had received the initial training and provided them with an additional 18-hours of training in January 1996. We measured the impact of this intervention on four separate indicators: promoter knowledge, technical content of promoter presentations, new client retention and new client knowledge.

Promoter Knowledge

The Population Council staff in South America developed a multiple choice test of promoter knowledge in Spanish. At the end of Phase 1, we translated into Creole and pre-tested a 60-item instrument. We determined that the test was too long and realized that it did not contain questions concerning NORPLANT which is a very popular method in Haiti. The validity of individual items were assessed using the "ITEMAN" method. A revised Test of Promoter Knowledge was developed with 40 multiple choice questions concerning the advantages, correct use, contraindications and side effects of modern methods of family planning. This instrument served as the 'before' test which was administered during July and August 1995 at the intervention sites and in October 1995 at the control site. A 50 item Test of Promoter Knowledge was developed as the 'after' measurement instrument which was administered at all sites in February 1996. We examined the responses to 37 questions which were included in both the before and after tests to measure any changes in Promoter knowledge. Both tests were administered to 25 promoters and 37 voluntary collaborators at the four intervention sites and to 14 promoters at the comparison institution. We eliminated from our comparisons the scores from any individual who was present for only one Test.

Technical Content of Promoter Presentations

Although the PSFP Project did possess a three-page assessment of Promoter home visits which had been developed by the IEC (Information, Education and Communication) Task Force, it had two major problems. First, the assessment focused more on communication technique than on information transfer. For instance, it checked whether the promoter greeted the prospective client

and looked her or him in the eyes. Less attention was given to the content of the message given. Second, the assessment was largely subjective, using categories such as well done, not well done, not done at all. In addition, it was not clear that the assessment was ever used by supervisors in the field.

We developed a single page assessment of the technical content of a promoter presentation to a prospective client. In addition to measuring the impact of training Promoters to use the ABC manual, we wanted to create a useful tool for any supervisor of staff who provided counselling to prospective family planning clients. The instrument, in Haitian Creole, uses code words or key phrases to represent each of the key messages which should be covered during an introductory presentation. For example, to measure whether the promoter seeks to determine the prospective client's reproductive intention, the instrument presents "desire additional children" and "when." The supervisor checks "desire additional children," if the promoter asks whether the prospective client wishes to have more children. Since information is not presented in the same order during each visit, we found it was more practical to summarize the technical information on a single side of one page.

Unfortunately, our instrument was not developed and field tested until after the ABC training intervention, so we were unable to conduct a 'before' measurement. We assessed 25 Promoters who had been trained in the use of the 'ABC' manual. We focused our assessment on 61 messages which should be presented to any prospective client prior to their choice of a method. Although the second half of the instrument covers additional key messages related to correct use, side effects and contra-indications, these messages are selectively presented, depending on whether the prospective client chooses a method available from the Promoter. To

assure a fair comparison, we restricted our assessment to the number out of the 61 initial messages that each Promoter presented.

Due to the logistical difficulty of assessing Promoter presentations during actual home visits to prospective clients, we decided to assess presentations made at family planning clinics. Two staff members from the INHSAC Research and Evaluation Unit individually assessed actual presentations made by each of the 25 Promoters to at least one prospective client. We used the first assessment made of 24 of the 25 Promoters. For the last Promoter, we used the second assessment since his first presentation was interrupted before the prospective client was offered a choice of method.

Survey of Client Knowledge

Since we were testing the knowledge of Promoters, and assessing the technical content of the presentations they make to prospective clients, we decided it was logical and important to evaluate the knowledge of clients, especially those clients who used methods provided by Promoters: condoms, oral contraceptives and vaginal tablets. After all, if a client does not 'know' key information about her or his method, s/he will have trouble, even if the Promoter knew and tried to inform the prospective client.

We developed a survey instrument which questioned clients about their current and past use of family planning. Separate sections were developed for current users of oral contraceptives, condoms and vaginal tablets. For all three methods we asked specific questions about their use of the method. For vaginal tablets users, for example, we asked: 'When do you insert a vaginal tablet? How do you insert it? For how long does it provide protection?'. For oral contraceptive

users, we also asked questions about contra-indications, side effects and dangers signs that require a visit to the clinic.

To learn what current and former clients knew about methods other than the one they were using, we asked what they knew about each of the following methods: injectables, oral contraceptives, condoms, vaginal tablets, NORPLANT, IUD, female and male surgical sterilization. The surveys also included questions concerning the client's reproductive experience and reproductive intention. The interview also examined current use of family planning and any apparent changes in methods compared to the records of the promoter. This is described in detail under the section 'New Client Retention.'

In July 1996, we examined the registers of 30 Promoters from the intervention sites and made lists of 774 new clients they had recruited during the trimester January through March 1995. The survey instrument was not completed and tested until October. In October, we made additional lists of 713 new clients recruited by 29 of the same Promoters during the trimester April through June 1995. We randomly selected 311 clients from the lists and asked seven trained interviewers to administer the survey at the home of each client during October and early November. We asked each promoter to take a trained interviewer to the home of her or his selected clients. If a client was not home, the interviewer attempted to make up to three visits to complete the survey. For a small number of clients who lived in areas particularly difficult to access, a single attempt was made. Successful interviews were conducted with 196 (63%) of the selected clients. The majority of the other clients were either not home (14%) or had moved (11%). We have no information concerning the cause of failure to interview 3% of the selected clients.

We were unable to conduct the Survey of Client Knowledge at the control institution prior to the training in the use of the 'ABC' manual which was provided to promoters at the intervention sites during October and November.

In February and March 1996, we repeated the survey at the four intervention sites and included a control site. Due to cutbacks in funding, several promoters had been laid off. At the intervention sites, 24 Promoters were available who had recruited 375 new clients during the trimester from July through September 1995. We randomly selected 152 of these clients and successfully interviewed 91 (60%). Again, the majority of clients who were unavailable had either moved (15%) or were not home (13%). At the control site, only 9 of their 18 Promoters were still working. Since they had recruited only 40 new clients during the trimester July through September, we attempted to interview all 40 and completed 26 interviews (65%). Only 5% of selected clients were not home for an interview, but 20% had moved away from the area.

By selecting the client on the Promoter register who immediately preceded any client who was not available, 22 additional clients were interviewed as replacements. In total, interviews were successfully conducted with 182 clients who initiated use of oral contraceptives, 108 condom users, 19 users of vaginal tablets and 26 clients using Depo-Provera; a small number of Promoters at one intervention site were also Health Agents and were able to administer Depo-Provera.

New Client Retention

Managers of family planning programs and USAID/Haiti staff were concerned that client retention might be excessively low. Since the PSFP Project had only begun a few years earlier,

emphasis had been placed on attracting new clients. Anecdotal evidence, and our reviews of Promoter registers, suggested that many new clients abandoned their method within a few months. Also, quarterly reports indicated that the total number of users did not increase by a third of the total number of new acceptors as presented in Table 1. At the end of December 1993, the project reported 78,747 users.

Table 1
PSFP Project during 1994
New Acceptors and Total Users

	Trimester			
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
New acceptors	19,046	23,466	22,143	21,450
Total users	82,930	97,817	102,648	108,075

With an emphasis on attracting new clients, there was concern that Promoters may have neglected existing clients. Monthly statistical reports tracked the number of new clients and total clients, but no special emphasis was placed on retention. There was also concern that Promoter registers exaggerated actual clients, since there were no mechanisms in place to verify their accuracy.

We determined to evaluate client retention by assessing the experience of new clients during the trimester January to March 1995. Since we expected that a large proportion who abandoned their method did so during the first few months of use, we decided to assess the number of clients still using a method in July 1995. We conducted random checks of some current clients taken from individual promoter registers by asking the responsible promoter to take us to the client. Our findings are presented under "Results.'

The second, more reliable method we utilized was accomplished in conjunction with the Survey of Client Knowledge. The current status of each new user was determined through series of questions. Of course, no interviews were conducted with clients who had moved, or with false clients. The status of these clients was tracked separately.

RESULTS

Promoter Knowledge

We did not demonstrate that training and use of the ABC manual improved Promoter knowledge. In fact, when we combined all the trained Promoters, the control Promoters had a greater increase in their mean test scores between Tests 1 and 2, despite the fact that they started with slightly higher scores. We separated out the new promoters at the intervention sites, since they had just started to distribute family planning methods and had not benefitted from the years of in-service training that the other promoters had received.

Table 2
Mean Scores on Pre- and Post-Test of Promoter Knowledge
Among Intervention and Control Groups

	Test 1 mean score (%) (Aug. 95)	Intervention	Test 2 mean score (%) (Feb. 96)	Diff.
Intervention Old Promoters (N=25)	24.8 (67%)	Monthly meetings Supervision & ABC training	25.2 (68%)	0.4
Intervention New Promoters (N=37)	21.3 (58%)	"	23.9 (65%)	2.6
Intervention Old & New Promoters (N=62)	22.7 (61%)	"	24.4 (66%)	1.7
Control Promoters (N=14)	25.8 (70%)	Monthly meetings & Supervision only	28.3 (76%)	2.5

When we used t-tests of independent samples to test the differences between the mean scores at Test 1 and Test 2, we did not find any statistically reliable differences between any of the groups. Therefore, the Test of Promoter Knowledge scores were not improved by training Promoters to use the ABC manual. However, when we used t-tests of independent samples to test the differences between the mean scores from a single test, we found some statistically reliable differences. First, we found that the Test 1 mean score at the control site (25.8) was higher than the mean score for all intervention Promoters combined (22.7). The control site Test 2 mean score (28.3) was also higher than the intervention Test 2 mean score (24.4). When we examined the scores of longtime Promoters only, we did not find any difference between Test 1 mean scores (24.8, 25.8) or Test 2 mean scores (25.2, 28.3). There was a statistically reliable

difference between new and control Promoter mean scores at Test 1 (21.3, 25.8) and between new and control Promoter mean scores at Test 2 (23.9, 28.3). We also found a statistically reliable difference between the Test 1 mean scores comparing old and new promoters at the intervention sites (24.8, 21.3).

Since many of the old Promoters at the intervention sites had participated in the first Test of Promoter Knowledge during Phase 1, we examined the difference between their test scores in February and those in July. There were 28 questions that were included on both tests, and the average increase among the 24 Promoters who had taken both tests was 5.9 points.

We also looked at educational attainment of longtime Promoters. Of the 25 Promoters at the intervention institutions, 16 (64%) had only finished primary school. By contrast, all six control institution Promoters whose educational level was reported had completed at least two years of secondary education.

Even the new Promoters did not fare poorly compared to respondents of similar tests in other countries where 15 to 25% of staff from NGOs score no higher than chance [Final Report, INOPAL II Project]. At Test 1, only one out of our 37 new Promoters (3%) scored less than 25% of the questions correctly; since it was a multiple choice test with four possible answers, this score is lower than one would expect even when selecting responses by chance. Out of 76 individuals tested, no one scored less than chance at Test 2.

Since we found no reliable difference between their scores, we combined the longtime Promoters from intervention and control sites. Only 36% (14 out of 39) answered more than three-quarters of the questions correctly at Test 1. However, 82% answered at least half of the

questions correctly. At Test 2, 46% answered more than three-quarters of the 37 questions correctly.

We also examined the responses of the 86 Promoters (new, old and control) who took Test 2. A sample question that 77 promoters answered correctly was:

The first injection of an injectable should be given to a woman:
a. 10 days after her period.
b. 6 months after delivery.
c. During the first five days of her period.
d. 5 days prior to her period.

A question that only 15 Promoters answered correctly was:

Once inserted, a vaginal tablet provides protection for:
a. 10 minutes
b. 1 hour
c. a half hour
d. one day.

We divided the 37 questions into three categories. Questions related to promoter-provided methods (condoms, oral contra-ceptives and vaginal tablets), clinic-provided methods, and physiology. Of the 18 questions concerning promoter-provided methods, 18 out of 86 promoters (21%) answered 9 or fewer questions correctly and 30 promoters (35%) answered 14 or more questions correctly. The method promoters knew best was condom: 35 promoters (41%) answered all four questions correctly. The method they knew least was oral contraceptives: 34 promoters (40%) answered four out of nine questions incorrectly and only 5 promoters (6%) answered all nine questions correctly.

Of the 14 questions concerning clinic-provided methods, 19 out of 86 promoters (22%) answered 7 or fewer questions correctly and 20 promoters (23%) answered 12 or more questions correctly. A full 42 promoters (49%) answered correctly all three questions concerning Depo-

Provera while only 14 Promoters (16%) answered correctly all four questions concerning the IUD. For physiology, 39 promoters (45%) answered at least four out of the five questions correctly.

Technical Content of Promoter Presentations

The most striking, and only statistically reliable, difference we found in the number of messages presented was between Promoters who did or did not choose to use the ABC Manual during their introductory presentations. On average the 15 Promoters who used the ABC covered 33 messages during their introductory presentations, while the 10 Promoters without an ABC Manual covered only 18 messages. When we used the t-test for independent samples to test the equality of the means, we found a 95% confidence interval of 5.2 to 24.6 as shown in Table 3.

Table 3
Number of Messages Covered in Introductory Presentations
Comparing Promoters who did and did not use the ABC Manual

	Messages covered	SD	CI 95%	p
ABC used (n=15)	32.6	12.4		
			(5.2, 24.6)	.004
ABC not used (n=10)	17.7	9.8		

We examined the results from the February 1996 administration of the Test of Promoter Knowledge to see whether the Promoters who chose to use the ABC Manual had higher scores. We had test scores for 13 Promoters who used the ABC and all 10 who did not use the ABC.

When we compared the two groups, we did not find any statistically reliable difference in their Test of Knowledge scores.

Since INHSAC had provided a second training in the use of the ABC to half of the Promoters, we also looked at the impact of this training on the use of the ABC manual. There were 14 Promoters who had received the additional training and 11 who had not. We did not find that a second training had any statistically reliable effect on the number of messages presented by the Promoters.

Survey of Client Knowledge

The most clear difference in client knowledge was among pill users comparing clients before and after the introduction of the ABC manual. The mean score among 38 pill users who had a Promoter using the ABC was 3.4 correct responses to seven questions, compared to a mean score of 4.3 correct responses among 31 pill users from the same institutions before the Promoters received training in the ABC. This statistically reliable difference also existed when we compared the same 38 pill users who had a Promoter using the ABC to the 15 pill users from the control institution who initiated use during the same trimester but who had Promoters with no ABC. There was a smaller, but still statistically reliable, difference when we compared 38 pill users who had three additional months of contraceptive use to the 38 pill users whose Promoters had been trained in the use of the ABC. We did not find a statistically reliable difference in knowledge about oral contraceptive use when we compared the two groups of pre-intervention pill users, one of whom had been using for three additional months. The results of these t-tests for independent samples are presented in Table 4.

Table 4
Mean Score of Oral Contraceptive Users
Responding to Seven Questions on Correct Pill Use

N	ABC use	Mean score	first use	months of use	t-value	2 tail Sig	(95% CI)
38	yes	4.3	Jul-Sep 95	5-7	3.70	.000	(.43,1.44)
31	no	3.4	Apr-Jun 95	4-7			
38	yes	4.3	Jul-Sep 95	5-7	3.30	.002	(.4,1.65)
15	no	3.3	Jul-Sep 95	6-8			
38	yes	4.3	Jul-Sep 95	5-7	2.04	.045	(.01,.94)
38	no	3.8	Jan-Mar 95	7-10			

Since the post-intervention survey was unable to include the clients from five Promoters, we compared the pre- and post-intervention mean pill use knowledge scores of the clients from the same 24 Promoters to assure that no bias was introduced. The mean score of the 37 clients whose Promoters used the ABC was 4.3 and the mean score of 26 clients whose Promoters did not use the ABC was 3.3. The 95% confidence interval was (.43,1.50) with a 2-tailed p-value=.001.

The responses to some individual questions were interesting. Nearly all users, 117 out of 122, responded that they took one pill each day. By contrast, nearly all users, 115 out of 122, did not know that they risked loss of protection against pregnancy when they missed taking a pill on two or more consecutive days. Among the clients whose Promoters had been trained to use the ABC manual, 32 out of 38 (84%) knew that when they missed taking the pill one day they should take two pills the following day. Only 58% (18 out of 31) of the comparison clients who

had the same Promoters, but who were surveyed before they had the ABC, knew what to do when they forgot to take the pill one day.

We also found that the introduction of the ABC manual made a difference in the number of correct responses given by new condom users to seven question concerning proper condom use. We did not find a statistically reliable difference when we compared each trimester of new users separately, so we combined the users who enrolled during two trimesters prior to the introduction of the ABC manual. The mean number of correct responses given by the 72 condom users who were surveyed prior to the introduction of the ABC was 3.8, while the mean number of correct responses given by condom users surveyed after the introduction of the ABC was 4.2 as presented in Table 5.

Table 5
Mean Score of Condom Users
Responding to Seven Questions on Correct Condom Use

N	ABC use	Mean score	first use	months of use	t-value	2 tail Sig	(95% CI)
22	yes	4.2	Jul-Sep 95	5-7	2.11	.037	(.03,.81)
72	no	3.8	Jan-Jun 95	4-10			

There were only two condom users in the control group, so we decided any comparison was meaningless.

When we examined the responses of clients to individual questions concerning correct condom use, virtually all clients in each group knew that a condom could be used only once and that it was put on the erect penis. A total of 79% of condom users knew that the condom should cover the entire penis, and 71% knew that care should be taken to avoid tearing the condom.

However, out of 96 condom users, only 11 (11%) knew that they should leave a little condom free at the tip of the penis to receive the discharge.

We surveyed only 13 current users of vaginal tablets. All 13 users knew that a vaginal tablet could be used only once, and 12 out of 13 users (92%) knew that improper use could result in an unintended pregnancy. By contrast, only 4 users (31%) responded that the vaginal tablet should be inserted ten minutes prior to sexual contact, only two users (15%) knew that a vaginal tablet provided one hour of protection and two other users knew that one should wait at least six hours before taking a vaginal douche.

Due to small numbers, the responses may not be very stable, but the survey showed that these vaginal tablet users knew certain things, and that overall their knowledge was dangerously inadequate.

In response to questions asking what they knew about methods other than the one they were using, clients demonstrated some interesting knowledge. Among 239 non-users of condoms, 95 (40%) stated that condoms protected against both pregnancy and STDs/AIDS. Of the 213 non-users of oral contraceptives, 72 (34%) knew that you have to take a pill each day. A total of 182 out of 285 non-users of injectables (64%) knew that you had to get an injection every three months; of course the name in Haitian Creole is 'the three-month injection,' so the knowledge is readily reinforced. Client knowledge about IUD was particularly low. Only 6 non IUD users (2%) mentioned that the IUD did not prevent you from having subsequent children, while 85 non-users of NORPLANT (25%) shared that knowledge. Three users of other methods mentioned that the IUD provides up to 6 or 10 years of protection, while 201 non-users of NORPLANT (60%) stated that it provides up to five years of protection. Only 19 respondents

(6%) mentioned that NORPLANT can be removed at any time. Concerning the permanence of surgical contraception, 136 users of other methods (41%) knew that female sterilization meant you could not have more children, and 105 (31%) knew that vasectomy was permanent. Again, the name in Haitian Creole, 'stop completely,' gives a good reminder.

We asked 98 of the new users how many more children they desired. A total of 46 (47%) responded that they did not want any more children; interestingly, only 39 of these clients were still using a method at the time of the survey which was only five to seven months after they initiated use. An additional 38 clients (39%) wanted one or two more children, and 14 other clients wanted three or more additional children; one client who already had a child, stated a desire for five additional children.

New Client Retention

On the whole, short term retention of new clients who adopted a method provided by a Promoter was quite high. Table 6 presents the status of clients four to ten months following adoption of a method for four groups separately since the period of observation was not identical. The status of the four groups combined is also presented. We randomly selected the new clients from Promoter registers as part of the Survey of Client Knowledge; clients were identified by trimester of first use and their subsequent status was determined during the survey interview. The precise duration of family planning use could not be calculated since the exact date of initiation was not recorded.

Table 6
New Client Method Use at Interview
Compared to Method of First Use

Group	Adoption	N	Months of use	Same Method	New Method	Non-user
1	Jan-Mar	128	7-10	66.4%	14.8%	18.8%
2	Apr-Jun	83	4-7	74.7%	16.9%	8.4%
3	Jul-Sep	99	5-7	75.8%	11.1%	13.1%
4	Jul-Sep	26	6-8	69.2%	7.7%	23.1%
1-4	Jan-Sep	336	4-10	71.4%	13.7%	14.9%

Despite differences in the period of observation, the results for each group are quite similar. We had expected that Group 3 users would have a higher rate of method change since their Promoters were trained to assist with method switching as part of the introduction of the ABC Manual. The most striking difference in the percentage who abandon all method use is between Groups 1 and 2 where 10% more clients have abandoned. Both groups had the same Promoters, but Group 1 had three additional months of use. Although the number of clients from the control group, Group 4, who abandon is higher, only 26 users were observed. Contrary to our expectation, the results suggest that early use of Promoter-provided methods is very stable. Only 50 out of 336 new users (15%) abandoned use during the period of observation.

More than two-thirds of the 336 new users of condoms, oral contraceptives, vaginal tablets or injectables were using the same method four to ten months after they initiated use. When we combined users of the same or a new method, fully 85% of new clients interviewed

were still using a modern method of family planning four to ten months after they accepted a method from a Promoter.

When we separated new users by method of first use, we found that only 9.3% of 108 new condom users had abandoned modern family planning four to ten months after first use. Nearly double that percentage, 18.1%, of 182 oral contraceptive new users were not using any method of family planning four to ten months after first use. Few interviews were conducted with users of vaginal tablets or of injectables, however, of the 19 new users of vaginal tablets, 5 clients (26.3%) were not using any method four to ten months after first use. For the 27 new users of injectables, only 2 clients (7.4%) were not using any method. Table 7 compares client use of family planning at the time of the interview to the method first adopted. We combined information from all four groups, so the period of observation varies from four to ten months.

Table 7
Method Used at Interview
Compared to Method of First Use

	Oral Contr.	Condom	Vaginal Tablet	Inject-able	Other	Non-User
First Method						
Oral Contr. (n=182)	118 (64.8%)	3 (1.6%)	2 (1.1%)	24 (13.2%)	2 (1.1%)	33 (18.1%)
Condom (n=108)	1 (0.9%)	91 (84.3%)	2 (1.9%)	3 (2.8%)	1 (0.9%)	10 (9.3%)
Vaginal Tablet (n=19)	1 (5.3%)	2 (10.5%)	9 (47.4%)	2 (10.5%)	0 (0.0%)	5 (26.3%)
Inject-able (n=27)	2 (7.4%)	0 (0.0%)	0 (0.0%)	22 (81.5%)	1 (3.7%)	2 (7.4%)

For comparison, we re-examined the Promoter registers at participating institutions after 1995 ended and counted the number of new clients each Promoter recorded during the first two trimesters. We then controlled the number of clients according to the registers who were using a method four months after the end of each trimester. The results are presented by institution in Table 8. The retention rate based on the Promoter registers was quite a bit lower than the retention rate we determined through direct client interviews. Of course, the interviewed clients excluded all those who had moved which accounted for an apparent increase in client continuity of more than 10%. The other striking result was the variability in retention rates between institutions.

Table 8
Continuity of Use Based on Promoter Registers

Institution	Trimester	New Users	Assessed	Continued Users	Percent
Ouanaminthe	Jan-Mar 95	238	Jul 95	195	81.9%
Fort Liberte	Jan-Mar 95	90	Jul 95	51	56.7%
Fort Liberte	Apr-Jun 95	52	Oct 95	33	63.5%
CRDSSP	Jan-Mar 95	212	Jul 95	171	80.6%
CRDSSP	Apr-Jun 95	249	Oct 95	200	80.3%
Compassion	Jan-Mar 95	149	Jul 95	84	56.4%
Compassion	Apr-Jun 95	94	Oct 95	47	50.0%
La Fossette	Jan-Mar 95	79	Jul 95	57	72.2%
La Fossette	Apr-Jun 95	72	Oct 95	37	51.4%
Total	Jan-Jun 95	1,235	4-6 mos.	875	70.9%

As part of our assessment of new client retention, we examined the number of false clients among Promoter registers. With one notable exception, we were impressed by the high percentage of valid clients contained in those registers. When asked to take us to meet selected clients, most Promoters were able to do so with no problem. Of the 311 randomly selected new clients who initiated use between January and June 1995, we only clearly identified 17 (5%) as false. Of these 17, 10 were clients of a single Promoter, who did not produce a single real client from the 10 randomly selected; the responsible institution immediately fired this Promoter. Several other clients could not be identified by a Promoter, but we could not clearly determine that they were. The Promoters were unable to take an interviewer to 8 clients (3%). A couple of the implicated Promoters claimed to provide the methods through a child survival colleague; the institution involved subsequently eliminated this practice. The remaining clients who could not

be identified were from one Promoter who had over 300 new clients during the six months under review. He was able to identify and take an interviewer to only 43 out of 46 of his clients who had been randomly selected.

In February and March 1996, out of 152 randomly selected clients at the intervention sites, there were none who were clearly false. Similarly, at the control site, we did not find any false clients out of the 40 who were randomly selected clients.

DISCUSSION

Our main finding that use of the ABC manual dramatically increases the number of key messages presented by Promoters during a supervised recruitment visit implies that these work aids should be made more widely available. The corollary finding that 36 hours of training does not increase the performance of Promoters on a test of knowledge compared to Promoters who had 18 hours of training suggests that retraining of Promoters should be more strategically planned and executed. Since 18 hours of additional training also did not increase the performance of Promoters in supervised recruitment visits, we could not demonstrate an impact of the additional training. On the other hand, the Test of Promoter Knowledge identified clear weaknesses in the understanding of most Promoters. Many Promoters could not identify correct responses on a multiple choice exam for questions related to contraindications and side effects of pill use, or of the correct use of Vaginal Tablets. Although the scores were higher than in some other countries, there is still quite a bit that Promoters did not know. In particular, Promoters need to be more informed about the methods they provide. Of course, there is a lot to know about for oral contraceptives, but it is important that Promoters know it, especially conditions which

are contraindications for pill use. It is difficult to imagine how a client will ever know how to properly utilize a vaginal tablet, if the Promoter who provides it is unclear. The weaknesses identified through the Test of Promoter Knowledge should be the basis of subsequent training content. Clearly, CBD programs need to address these weaknesses through monthly in-service training sessions and strengthened field supervision.

Similarly, the results of the Survey of Client Knowledge, identified key weaknesses among many clients which should be systematically addressed by program staff. This is particularly true for users of a particular method. The responses of clients concerning methods other than the one they used should be taken as general indications of knowledge. Since that part of the survey simply asked clients to say what they knew about each of the methods they were not using, the fact that they did not mention a certain fact does not really prove that they did not know about it.

The increase in client knowledge that we found could very well be the result of the introduction of the ABC manual. The clients at the control site had Promoters with higher education levels who scored higher on the Test of Knowledge. In addition, there were a smaller number of new clients for each Promoter at the control site, so presumably they were able to provide them with better care. However, since we were unable to conduct a pre-test at the control institution, we can not rule out the possibility that the increase in client knowledge was the result of Promoters being present while interviewers conducted the pre-survey at the intervention sites.

Our findings contradict the summary statistics published by the PSFP Project concerning client retention. The institutions we examined may have had slightly higher performance, but it is unlikely that they were especially different from rest of program institutions. A more likely

explanation is that clients are counted as new clients each time they switch methods, or switch providers (including switches between CBD and clinic distribution, and when they move), or when they re-start after a short pause. Although the number of clients we found who abandon is lower than expected, they should be targeted for visits by Promoters and by their supervisors; it is highly unlikely that many of them attained their reproductive objectives so quickly, therefore, they are most likely frustrated users and prime candidates for a change to a different method. It would be useful to collect data from new clients concerning their reproductive intention, so that the success of a program could be measured against client desires.

The number of false clients was surprisingly low, but even this low number apparently was reduced by the simple procedure of conducting random checks. The small users fees which were introduced to the program would also have the effect of reducing client fabrication.

The primary reason we undertook this OR project was to improve the performance of Promoters through enhanced supervision. Nearly all of the instruments which were developed could be successfully used by supervisors during their regular supervision visits. The fact that many Promoters had not received a supervision visit for several months is a key problem that program managers need to address, if they want their clients to receive better services.

Table 1
Distribution of Users

	Trimester	
Source of Method	Apr-Jun 1994	Jul-Sep 1994
Community-based users	52,483 (54%)	54,426 (53%)
Clinic-based	45,334 (46%)	48,222 (47%)
Total Users	97,817 (100%)	102,648 (100%)

Are you a current user of family planning? (yes/no)
If yes: Which method? When did you start using?
If no: Were you ever a user?
If yes: Which method? When did you start?
When did you stop using? and why?

Promoter Knowledge

Apparently the increase in Promoter Test of Knowledge scores was related to greater familiarity with the multiple choice test, as well as with the style of the questions, at the second administration. The higher education of Promoters from the control site is probably responsible for their higher scores at both Time 1 and Time 2.